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HIV AID TO AFRICA WILL MEET OBSTACLES 12

HEALTH CARE NEWS

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Congress To Be Exempt from Medicare Reform

Conrad F. Meier

The U.S. House of Representatives on July 7 passed legislation guaranteeing federal employees and members of Congress will have prescription drug benefits better than those available through Medicare when they retire. Later that month, the Senate passed a similar measure.

Even as Congress wrestles with reconciling House and Senate versions of a Medicare reform package that includes prescription drug coverage, the new bills guarantee drug benefits for civilian federal retirees cannot be reduced to the level proposed for Medicare.

EXEMPT continued on page 16

Managed Care Planned for Georgia Medicaid

Conrad F. Meier

Georgia state lawmakers have begun reviewing proposals for a major overhaul of the state Medicaid program, seeking to control costs while continuing to provide health care coverage for roughly 1.2 million poor, elderly, and disabled citizens.

Forty-two companies and organizations, including some of the biggest names in the private-sector Medicaid HMO and home health care field, are vying for a chance to help Georgia overhaul its crumbling Medicaid system. As Medicaid HMOs continue to multiply and prosper nationally, many view Georgia

GEORGIA continued on page 14

Edwards Seeks Mandatory Coverage

Conrad F. Meier

Sen. John Edwards

Presidential candidate Senator John Edwards (D-North Carolina) unveiled on July 28 a $53 billion health care reform plan he says will provide health coverage for uninsured U.S. residents. Edwards' proposal would require parents to provide health coverage for children through age 21.

EDWARDS continued on page 15

Drug Reimportation Passes House

Getty

Springfield, Massachusetts, Mayor Michael Albano and his diabetic son Mikey, 13, sit at the kitchen table with Mikey's supply of Canadian prescription drugs. Springfield is the first municipality in the nation to supply some city workers and retirees with prescription drugs purchased from Canada.

Joe Moser

On July 25, the House of Representatives passed H.R. 2427, the Pharmaceutical Market Access Act of 2003, by a vote of 243 to 186. Eighty-seven Republicans joined 155 Democrats and one independent in supporting the measure.

The legislation, introduced in mid-June by Rep. Gil Gutknecht (R-Minnesota), would allow U.S. consumers, pharmacists, and wholesalers to reimport prescription drugs from 26 countries with minimal oversight by the Food and Drug Administration (FDA).

While the measure's supporters say it will give U.S. consumers easier access to low-cost prescription drugs, experts say the legislation will flood the country with dangerous counterfeits and import foreign price controls, killing research and development in new life-saving medications.

Interests Mobilized

The debate proved to be one of the most contentious of the year, dividing conservatives and mobilizing such varied interests as the Traditional Values Coalition and the Leukemia and Lymphoma Society.

On the day of the vote, the National Association of Manufacturers, U.S. Chamber of Commerce, and National Medical Association ran full-page ads

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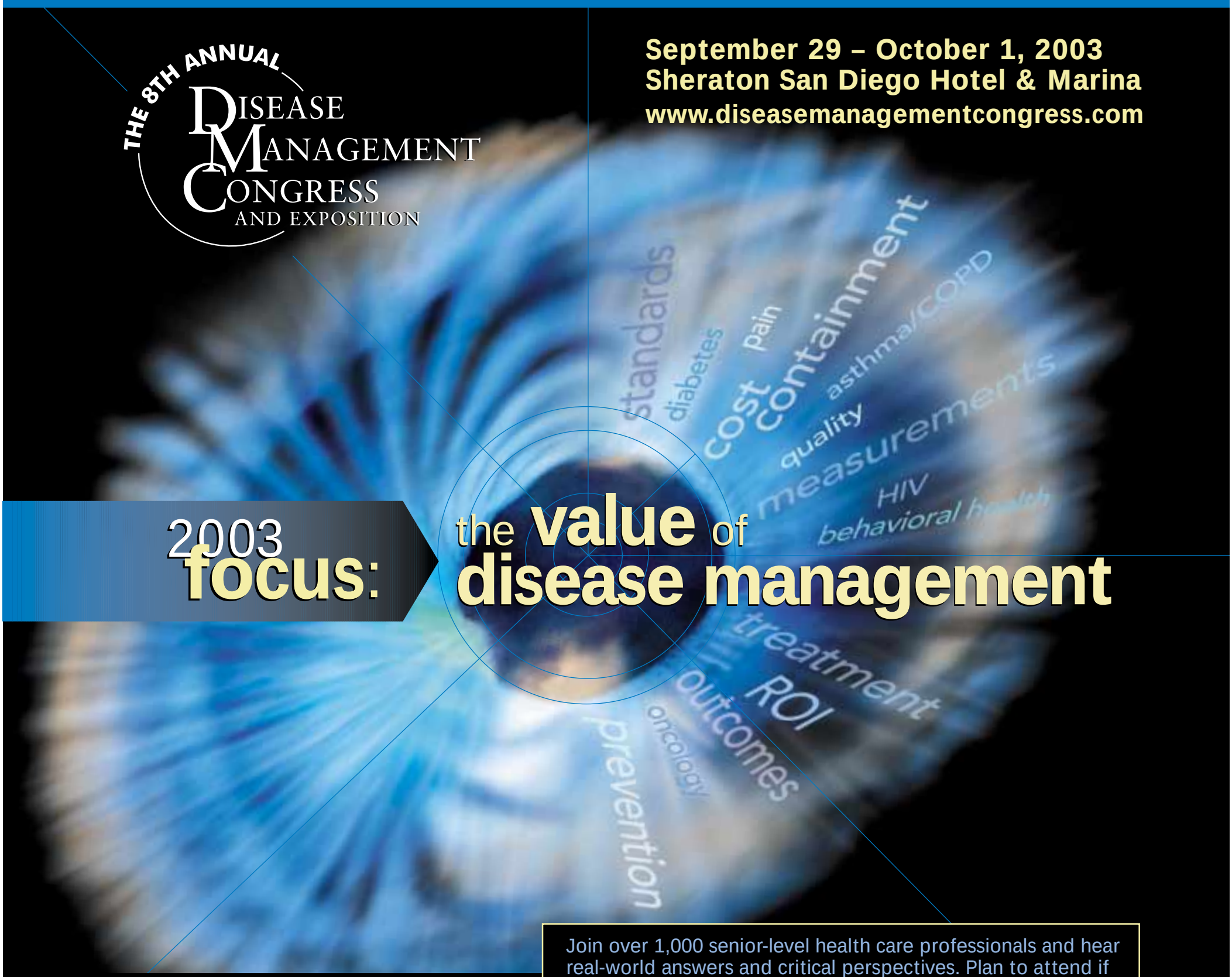

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Medicare Conferees Agree on Some Basics

Conrad F. Meier

Members of the conference committee charged with reconciling the House and Senate versions of Medicare reform legislation have reached agreement on some relatively uncontroversial and basic provisions.

The provisions would clarify the rights of Medicare beneficiaries and doctors, hospitals, and other providers. The clarifications are intended to make less necessary micro-managing regulation by the federal government, while allowing federal prosecutors enough latitude to investigate fraud.

Conference committee Chair Bill Thomas (R-California) said, "Physicians are spending too much time struggling with paperwork and not enough time on patient care."

The provisions on which agreement has been reached would:

- Create an ombudsman for Medicare beneficiaries.
- Move Medicare administrative law judges from under the Social Security Administration to under the authority of the Department of Health and Human services.
- Establish a toll-free hotline beneficiaries could use to obtain answers to questions about Medicare.
- Reform the appeals process to simplify appealing Medicare's denial of a claim.
- Streamline the process for reviewing doctors' billing records.
- Simplify the process by which doctors correct billing mistakes, appeal actions against them, and repay Medicare when they over-bill the program.
- Generally exempt doctors from penalties if they can prove they violated Medicare rules because their actions were based on false written advice from the government.
- Generally prohibit Medicare officials from applying new interpretations of rules retroactively.
- Prevent Medicare officials from assessing large penalties against hospitals by extrapolating the number of errors a hospital has committed based on a small sample of Medicare claims.

Conference committee member Representative Nancy Johnson (R-Connecticut) said "the provisions will have as much impact on people's lives as any [other] section of the [final] bill."

Senator Charles Grassley (R-Iowa) said the final Medicare reform bill would not hinder fraud investigations, but will "preserve the integrity of the False Claims Act, a very potent weapon in the war against [Medicare] fraud."

Reuters

(R-L) Sen. Craig Thomas (R-Wyoming), Sen. Charles Grassley (R-Iowa), and Senate Majority Leader Bill Frist (R-Tennessee) sit together at the first meeting of the conference committee on Medicare on Capitol Hill in Washington, DC, July 15, 2003.

Room for Negotiation?

House and Senate negotiators appeared to feel good about finishing a portion of the final reform bill before leaving for Congress' August recess, suggesting the agreement could prompt further bipartisan compromises on more contentious provisions.

"[T]he cost impact of these bills is more than a one-time bump. It is a permanent acceleration of spending growth."

Jeff Lemieux
Progressive Policy Institute

Representative Billy Tauzin (R-Louisiana) stated in an Associated Press interview, "This is perhaps the low-hanging fruit of this legislation, but it does represent a huge accomplishment." Senate Majority Leader Bill Frist (R-Tennessee) agreed, promising, "Already, we have been able to bridge dozens of differences over the course of one week since the conferees' meeting July 15. There is much more to do. And, in the weeks ahead, we will do what is necessary to reach agreement in all areas."

The *New York Times*, however, reported lingering animosity between the parties, noting Representative Charles Rangel (D-New York) "half-facetiously" said he hoped Republicans would at least inform Democrats where and when meetings on the "big decisions" ahead would occur.

Conferees have adopted an ambitious schedule, requiring staff members to work through the August break to meet the Bush administration's request to finish work on a final reform bill this year.

Much More To Be Done

Populated by leaders of both houses, the conference committee has yet to tackle disagreements over the heart of Medicare reform: the language that will provide prescription drug benefits for senior citizens.

The Congressional Budget Office estimates the prescription drug benefits outlined in both versions of the Medicare reform drug bill would cost more than $400 billion over the next 10 years. That 10-year cost, moreover, is only the beginning.

Since prescription drug coverage would be a new entitlement under Medicare, notes Jeff Lemieux of the Progressive Policy Institute, "the cost impact of these bills is more than a one-time bump. It is a permanent acceleration of spending growth."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Drugs

Continued from page 1

in the Capitol Hill newspaper *Roll Call* opposing reimportation.

The White House and FDA also weighed in, opposing the measure. They warn it endangers patients by allowing potentially counterfeit, adulterated, and unapproved drugs to enter the country.

FDA Commissioner Mark McClellan said the anti-counterfeiting measures in the Gutknecht legislation would raise the cost of prescription drugs by $2 billion. The Congressional Budget Office concluded, in a July 22 report on the projected costs of a prescription drug benefit for Medicare, that reimportation would not reduce drug costs for American consumers. (See the Galen Report on page 17 for a summary of this CBO report and how to find it on the Internet.)

"[The Gutknecht bill] will allow this country to be flooded with unsafe, counterfeit drugs; drugs that will not do what they should; drugs that are unsafe; drugs that will kill the American people."

Rep. John Dingell
D-Michigan

Nevertheless, House lawmakers passed the legislation. Many said they did not believe the safety risk was a legitimate concern. "The safety issue absolutely will hold no water anywhere, and they know it," said Rep. Louise Slaughter (D-New York).

Rep. John Dingell (D-Michigan) disagreed. "[The Gutknecht bill] will allow this country to be flooded with unsafe, counterfeit drugs; drugs that will not do what they should; drugs that are unsafe; drugs that will kill the American people."

Preserving Profits

Other observers said the key issue in the reimportation debate had to do with preserving the profits of pharmaceutical companies.

"They say it is about safety. It is not about safety; it is about money. They say it is about the health of seniors who might be taken in by counterfeit drugs. It is not about that. It is about money, the money that the pharmaceutical companies are making on the backs of the American people," said Rep. Dan Burton (R-Indiana).

Opponents of the measure did not disagree that profits—which make possible the research and development efforts of U.S. pharmaceutical companies—are an important aspect of the debate. "I want to lower drug costs for the seniors in my district, but not at the risk of stifling the very innovation that creates the drugs in the first place," said Rep. Phil Crane (R-Illinois).

Unlike Crane, many Americans appear not to understand the economics of the drug industry. During a C-SPAN broadcast of debate over the Gutknecht measure, viewers were encouraged to call in with their comments. Those whose thoughts were aired grumbled about the "outrageous" profits the pharmaceutical industry must be making if the same pill cost $3.25 in the United States and $1.30 in Germany.

What those callers fail to understand is that the price differential is a creature of governments. Many foreign countries keep prescription drug prices artificially low with government-imposed price controls. Because consumers in price-controlling nations don't pay much toward research and development costs, Americans pay more.

Conservatives Divided

Some conservatives supported reimportation on the basis of free trade. They argued drug prices in other countries would rise with reimportation, easing the burden on American consumers who subsidize the research and development costs for countries with price controls.

"American policy has always been based on the principle that our economy is strengthened by free trade. ... There is no good reason why pharmaceuticals should be an exception to the rule," said Rep. Ron Paul (R-Texas).

Others say buying drugs in a foreign country with price controls has little in common with free trade.

Said Rep. Jim McCrery (R-Louisiana), "Americans pay an unfair share of the research and development costs for pharmaceuticals in the world; but the proper way to address that is not by abandoning our free market principles and importing price controls, and that is what this bill would do."

What Happens Next

The Gutknecht bill now moves to the Senate. Fifty-three Senators have said they would oppose any measure that bypasses the authority of the Secretary of the Department of Health and Human Services to implement the law based on safety and cost-effectiveness considerations.

While Senate passage of the legislation as a free-standing measure appears unlikely, supporters will lobby for its inclusion in the Medicare conference committee report. By virtue of its passage in the House, it becomes the official stance of the House on the reimportation issue in negotiations with the Senate on the Medicare bill.

Joe Moser is a health policy analyst at the Galen Institute, a nonprofit public policy research organization based in Alexandria, Virginia. The views expressed are the opinions of the author and do not necessarily reflect the views of the Galen Institute.

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Drug Reimportation Bill Called "Risky"

Conrad F. Meier

The idea of letting Americans buy prescription drugs from 26 foreign countries at reduced prices faces a formidable hurdle in the Senate. Even with House approval of the drug reimportation measure, high-profile Senators of both political persuasions worry the safety risks surrounding reimported medications may be too great to ignore.

Proponents of the House bill admit the future of their legislation is uncertain. However, they say the July 243-186 vote to approve the measure—opposed by the White House, Republican leaders, the Food and Drug Administration, and the pharmaceutical industry—was evidence of growing grassroots demand for less-expensive prescription drugs.

"I don't know if we are going to win this fight," said Rep. Dan Burton (R-Indiana), a conservative who joined some of the House's most liberal Democrats in supporting the bill. But "we sent a very strong message" to the pharmaceutical industry, said Burton, who believes firms will have no choice but to reevaluate the prices they charge U.S. consumers.

The House bill, introduced by Rep. Gil Gutknecht (R-Minnesota) and cosponsored by Jo Ann Emerson (R-Missouri) and Rahm Emanuel (D-Illinois), requires the Department of Health and Human Services (HHS) to establish a system to allow the reimport of FDA-approved drugs from FDA-approved facilities in Canada, the European Union, and seven other nations. The measure also would require that reimported medicine be shipped in special packaging designed to discourage tampering and counterfeiting.

The Gutknecht measure goes well beyond reimportation language present in the Senate and House Medicare reform measures, currently being reconciled in a conference committee. Both chambers' Medicare bills would allow reimportation only from Canada, and both would require HHS to certify the reimported drugs as safe.

KRT

Irene Dworkin, 75, figures she'll save about $200 a month if she fills her prescriptions with Discount Drugs of Canada, a Delray Beach, Florida distributor.

No Guarantee of Safety

Twice before, Congress has passed legislation addressing drug reimportation. Both measures required HHS certification of a drug's safety before reimportation would be permitted. Neither Donna Shalala, who served as HHS secretary during the Clinton administration, nor Tommy Thompson, the current secretary, has certified as safe any reimported drugs.

Fifty-three Senators, including Edward Kennedy (D-Massachusetts) and Orrin Hatch (R-Utah), have signed a letter opposing efforts to make it easier to reimport drugs into the U.S. from foreign countries. "We do not believe it would be prudent to remove these vital safeguards," the Senators write, "especially when Congress is enacting a Medicare measure that includes improved access to more affordable generic drugs."

The Pharmaceutical Research and Manufacturers of America, which represents the nation's name-brand drug industry, said it was encouraged by the senators' opposition to legislation they said would jeopardize the safety of the country's medicine supply and import foreign governments' price controls.

James Glassman, resident fellow at the American Enterprise Institute, raises a different concern. "It is not too dramatic to say that, if it becomes law, this bill will make Americans sicker and shorten their lives. The reason is simple. The bill would introduce Canadian price controls to the United States. The results are eminently predictable. If U.S. drug companies are forced to sell at prices that prevail in Canada and Europe, they will sharply curtail, or in many cases abandon, the development of new pharmaceuticals."

The Bush administration called the bill "dangerous legislation." Food and Drug Administration Commissioner Mark McClellan warned the measure "creates a wide channel for large volumes of unapproved drugs and other products to enter the United States that are potentially injurious to public health and pose a threat to the security of our nation's drug supply."

Supporters of the Gutknecht bill vowed to reject any Medicare reform bill that does not include what they call a "market access provision" to allow U.S. residents to purchase prescription drugs from other nations.

Pipeline to Consumers

Were the Gutknecht bill to become law, U.S. pharmacies would likely reimport prescription drugs. Todd Andrews, chief spokesperson for the pharmacy chain CVS, said "if a program were put into place that gave us the opportunity to purchase high-quality medications at substantial savings for ourselves and our customers, then we would certainly take advantage of that program ... whether it's overseas or domestic."

Joe Smith, president of the National Community Pharmacists Association, which represents about 25,000 independent pharmacies, said the group would consider the practice. "In the worst-case scenario, I think, yes, we would go overseas to get drugs for our stores. And we would probably do it as a buying group or through our wholesalers ... rather than me trying to deal with the differences of currencies and importation laws and duties."

But not all pharmacies would accept reimportation. Craig Fuller, CEO of the National Association of Chain Drug Stores, told the *Washington Post*, "U.S. wholesalers that purchase medications from pharmaceutical companies and sell them to retail pharmacies may not import prescription drugs from other nations, because the wholesaler obviously wants to have assurance that the products that they are selling to the retailers are safe."

Fuller added, "Until you can be assured that the medications you are importing in fact meet the high standards that we have today, people are going to be reluctant to do that. At this point, it would be too hypothetical to speculate how retailers might go about doing that."

"The best solution," writes Glassman, "is for all nations to do what the U.S. does: Establish a relatively free market in drugs. If that happened, drug companies would be able to afford to invest even more than the $30 billion a year they currently put into research and development. The world would have more new medicines, and people would be healthier and live longer."

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INTERNET INFO

James Glassman's essay, "Importing Socialism," is available online at **http://techcentralstation.com**.

What Is Drug "Reimportation"?

Diane Carol Bast

Drug reimportation refers to allowing prescription drugs produced for use in another country to be imported into the U.S. for sale here instead. Because these drugs were often originally manufactured in the U.S., and then exported abroad, their return to the U.S. has been termed "reimportation."

"Under current law," explains attorney Demetrios L. Kouzoukas, "only pharmaceutical manufacturers themselves are allowed to reimport prescription drugs, and even then only under the Prescription Drug Marketing Act of 1988."

Current legislative proposals for reimportation, such as the Pharmaceutical Market Access Act of 2003 (H.R. 2427), approved in the House in late July and now pending in the Senate, would allow other parties—retail pharmacies and individual patients, for example—to reimport drugs from 26 foreign countries.

Supporters of reimportation say the practice would allow U.S. patients to purchase prescription drugs at lower prices than they currently pay. The text of H.R. 2427, for example, asserts "allowing open pharmaceutical markets could save American consumers at least $635 billion of their own money each year."

Detractors disagree, saying reimportation will limit the availability of drugs in the foreign countries from which reimportation to the U.S. is allowed. "This is exactly what happened with AIDS drugs to Africa," notes Sally Pipes of the Pacific Research Institute, "when roughly one-fifth of GlaxoSmithKline's deeply discounted AIDS shipment to Africa was resold in European markets."

Opponents of reimportation also warn of other negative consequences, among them dangers to patient safety, due to the reimportation of counterfeit drugs or those beyond their expiration dates, and reduced investment in essential research and development by pharmaceutical companies.

Diane Carol Bast is vice president of The Heartland Institute and editor of Health Care News. *Her email address is* **dbast@heartland.org**.

INTERNET INFO

For more information, see "Rx Reimportation: A Legislative History," by Demetrios L. Kouzoukas, *Health Care News*, November 2002.
http://www.heartland.org/Article.cfm?artId=10669

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Riding the Rx Highway

Duane D. Freese

Almost everyone has heard about Americans, many lacking prescription drug insurance coverage, boarding buses to Windsor, Niagara Falls, Quebec City, New Brunswick, and Vancouver, all to do what is every American's God-given right—hunt for bargains.

And oh, are there bargains to be had. Lipitor, the anti-cholesterol drug, which can cost up to $250 in the United States, can be purchased in Canada for as little as $134. Ninety tablets of the breast cancer treatment drug Tamoxifen, which can cost $127 in the U.S., can sell for as little as $18 in Canada.

While not all bargains are of that magnitude, in general prescription drug prices run substantially less north of the border than in the lower 48—or in Alaska or Hawaii, for that matter.

Traffic Runs Both Ways

Border crossings, though, are a two-way street. Not only do Americans go north, but Canadians are regularly heading south—not for lower prices, but to take advantage of medical care they can't get up there.

"[N]ot only do Americans go north, but Canadians are regularly heading south—not for lower prices, but to take advantage of medical care they can't get up there."

In July 2002, a Canadian consumer organization—Consumer Advocare Network (CAN)—put 14 Canadians aboard a bus so they could get health care services in Bangor, Maine—services that Canada's single-payer system, with its emphasis on price controls, makes unavailable in a timely manner there.

Tony Lordon of Saint John, New Brunswick is a 17-year family physician. He said the patients he put on that bus are but a small sample of thousands of Canadians who annually come to America. They can afford to pay for better services; they cannot afford the delays Canada imposes in getting them. As Lordon says, "health care delayed amounts to health care denied"—especially to ill patients who may die while waiting for the right drug or advanced treatment.

One example is a 57-year-old male with hyperlipidemia (high cholesterol) and a family history of early death from heart attacks. He has tried the approved drugs in Canada, but suffered bad side effects; the drug Niaspan might not produce those effects, but he can't get it in Canada. So he travels to Bangor.

Another is a 65-year-old woman with type 2 diabetes. She shifted from a private health plan to her provincial health care plan for retirees. She used Avandia for years under the private plan because it didn't produce the side effects of weight gain and hypoglycemia she suffered from another drug. But Avandia isn't on the province's approved drug list, so she'd have to take the one with the side effects—or come to the United States to buy Avandia.

Similarly, a 44 year-old female with anxiety disorder and panic attack needs time-released Paxil. It's not approved in Canada, so she's boarded the bus, too.

Other Canadian patients are coming to the U.S. for other treatments often delayed by Canada's cost controls.

A 45-year old woman, for example, is going blind from what appears to be a fungal eye infection. It will take her eight to nine months to get a referral to an ophthalmologist in Canada, because price controls have induced a shortage of physicians, particularly specialists. Her appointment in Maine came in a couple weeks.

A 76-year-old heart disease patient suffers disabling angina that external counter pulsation could relieve. His condition isn't critical, though, so the Canadian government will keep him disabled rather than give him the treatment he'll get in the U.S. when the bus reaches Bangor.

Dying to Get Care

Dr. Lordon noted that Canada's health care administration is ready to step in when a patient is dying or critically ill. But "why should you have to wait until you are dying?" he asks.

"We have triage here (in Canada) to decide which cases are most in need of care," echoed Durhane Wong-Rieger, chairperson of CAN. "The problem is the people at the end of the line who have to wait six to eight months for care urgently need it now, not when they are desperately ill."

The good news for all these Canadians—and for the Americans crossing the border into Canada—is that the pills, physicians, and treatments are available. But as Wong-Rieger points out, they are available only because the health care system in America has a more generally free market that promotes innovation.

Biting the Hand that Feeds

Some U.S. politicians and self-styled consumer advocates dismiss the innovation that characterizes U.S. health care, all in the name of getting their constituents a price break on drugs or medical care. For example, the U.S. House has passed, and the Senate is considering, measures to promote the reimportation of drugs sold by American pharmaceutical companies to Canada back to pharmacies and patients in the United States. That proposal would undermine incentives here for innovation, ultimately importing Canadian price controls to the United States.

KRT

Barbara Waks, 69, of Aventura, Florida, estimates she saves $200 a month on her drug bill by getting her prescriptions filled in Canada.

Proponents of reimportation claim it will save American consumers 35 percent on their drug costs. Given that pharmaceutical company profits amount to less than 20 cents on a dollar of sales, that suggests the pharmaceutical companies and their investors will be satisfied with losses of 15 percent. Not likely.

The reason Canada has lower prices has a lot to do with other differences between the two nations. For example, Canada not only imposes price controls on drugs, but also caps the liabilities of drug companies, something the main proponents of reimportation in the U.S. refuse to do. Canadians also have a lower standard of living than we enjoy in the U.S., which means they often substitute more labor-intensive treatments for higher-tech ones. Will Americans be willing to spend more time in the hospital rather than treat their illnesses at home with drugs? Would that really save any money?

Free Riders

Most of all, though, as Wong-Rieger points out, the proponents of reimportation ignore the reality that Canadians represent 2 to 3 percent of the prescription drug market; Americans, 65 percent. "We get a free ride on the research and development of the American market," she noted.

The Canadians are much like wait-listed passengers at airline ticket desks. They are few in number, and it is profitable to sell discounted tickets to them in order to fill the plane ... but only so long as a sufficient number of other passengers pay full fares.

If you insist that *all* passengers be given the discounted fares offered to wait-listed passengers, you'll have fewer flights and more airline bankruptcies. In the case of drugs, you'll see fewer new and innovative therapies, and perhaps pharmaceutical firms closing up shop.

Indeed, that's exactly what Europe today is facing. On July 10, European Union health ministers met in Rome to discuss reforms that would allow drug companies to offer their drugs at any price they want. The reason: Under a regime of price-fixing by governments over the last decade, innovation in the U.S. drug industry has outpaced Europeans by more than two to one. Employment in the U.S. pharmaceutical industry has neared 200,000, while it's fallen below 100,000 in Europe.

"Europe has really lost out in this area over the last 10-15 years because it was so much focused on cost and prices," Thomas Cueni, general secretary of Interpharma, a Swiss-based trade association, has noted. Switzerland does not control prices and is home to three of the world's largest biotechnology companies. "By and large, growth is driven by innovation, and pharmaceuticals are an extremely important part of that."

American politicians may think they're doing their constituents a huge favor through reimportation, but in the end, their constituents will have fewer new and innovative drugs to buy. And unlike the Canadians who come to the U.S. for better care, Americans will have no place to go.

Duane Freese is a columnist for Tech Central Station **http://techcentralstation.com** *and former editorial writer for* USA Today. *His email address is* **dfreese@techcentralstation.com**.

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INVESTIGATIVE **REPORT**

Overcharging the Uninsured

part 1 in a series

Hospital Pricing: Separate and Unequal

Randy Suttles and
Merrill Matthews, Jr., PhD.

There once was a time, not that long ago, when the U.S. health care system was geared to help the poor and uninsured. Today, it is geared to dramatically overcharge them.

Wealthy and middle-income workers with insurance get the best price for a hospital stay; poor, uninsured people get the highest price—and an aggressive collection agency if they can't pay the bill (which they usually can't).

Why Things Changed

Prior to the explosion of managed care in the late 1980s and early 1990s, most health care providers charged a fee for their services and fully expected patients—or their insurers—to pay. However, they also felt a commitment to helping the poor, frequently reducing their bills or providing the care at no cost.

But change was in the air. Although the Medicare program initially paid hospitals their "usual and customary" charges, Congress imposed on Medicare a system of hospital price controls beginning in 1984. Eventually, the Medicare reimbursement schedules became the benchmark for the HMOs, which leveraged large numbers of patients to negotiate hospital prices only slightly higher than what Medicare paid. Preferred Provider Organizations (PPOs) also negotiated discounts, but they were usually calculated as a percentage of the hospital's gross charges.

Medicare is required to "set rates that cover the costs efficient providers would incur in furnishing care to beneficiaries." However, while Medicare's target is to pay hospitals 1 percent above costs, the estimated average for 2003 will be 3.9 percent, according to the current MedPAC Commission Report.

Through the 1990s, as managed care expanded to cover almost all of the under-age-65 insured population, hospitals boosted their gross charges dramatically. This increase had little impact on Medicare and the HMOs, which still paid their negotiated rates. But it had a major adverse effect on PPOs and the uninsured. Here's why:

- Giving a PPO, say, a 30 percent discount off an artificially inflated charge would bring in a lot more money than hospitals would receive from Medicare and most HMOs, which meant PPO premiums would have to rise even more dramatically.
- The number of uninsured patients is so small, their political and economic power so weak, and their knowledge of how the system really operates so limited that hospitals can charge whatever they choose—and in most cases get it. Thus, the health care system flip-flopped from one in which insured workers and the wealthy paid the most to one in which they get the lowest prices—which they don't have to pay anyway because of their insurance—while the uninsured are stuck with the highest bills.

The Cost-to-Charge Ratio

Every hospital has a "chargemaster"—a master file of all costs and charges for every hospital service, drug, or procedure—which is used to generate both a hospital invoice and the standard required federal UB-92 form that accounts for all inpatient or outpatient hospital procedures.

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The Centers for Medicare and Medicaid Services (CMS) compiles this information annually in its Medicare Cost Reports. The reports detail every hospital's costs and charges by department and cost centers. Thus, Medicare knows each hospital's average daily costs to provide care for a patient.

Moreover, Medicare knows what every hospital collects from Medicare, managed care, and the "self-pay" (i.e., uninsured) patients. The ratio between what a day in the hospital costs and what the hospital charges is called the "cost-to-charge ratio" (i.e., the cost divided by what the hospital charges). The closer a cost-to-charge ratio is to 1, the less difference there is between the actual costs and the hospital's gross charges.

"On average, HMOs pay 12 percent above what Medicare pays... But the uninsured receive artificially inflated bills that can be 200 to 1,100 percent more than what Medicare or insured patients pay."

The cost-to-charge ratio varies from state to state. As Table 1 shows, the average cost-to-charge ratio for California is .328, which means hospitals there are charging roughly three times their costs. According to CMS, Nevada, with an average hospital cost-to-charge ratio of .282, charges more than any other state, followed by California and Alabama (.338).

By contrast, Maryland has the best statewide ratio, .769—the state's hospitals charge 30 percent more than the actual costs. North Dakota is at .609, for an average charge of 64 percent above cost.

Insured patients don't pay the full charge because of Medicare, Medicaid, or managed care discounts. The only ones actually paying the gross charge are the uninsured, who are typically poor and minorities, especially Hispanic.

How Much Do the Uninsured Pay?

Table 2 identifies the cost-to-charge ratios at three urban hospitals. As the table shows:

- The average operating cost per patient per day at St. Louise Regional (Catholic) Hospital in West Gilroy, California, is $1,376. An uninsured patient would be billed $5,508.
- Palm Beach Gardens Hospital in Florida reports a daily cost of $1,501, but it charges the uninsured $7,414.

On average, HMOs pay 12 percent above what Medicare pays, according to the MedPAC Commission. But the uninsured receive artificially inflated bills that can be 200 to 1,100 percent more than what Medicare or insured patients pay.

Insult to Injury

Unfortunately, gross over-charging is not the full extent of the outrage. After charging the uninsured several times more than an insured person would pay, some hospitals aggressively try to collect the inflated bills.

Case Study: Carlos Colon. The *Chicago Sun-Times* tells of Carlos Colon, a Home Depot employee, who had a cyst removed from his lower back before his employer-provided insurance policy kicked in. He was hospitalized for a week and billed $74,396—"10 times what an insurance company would pay," according to the *Sun-Times*. He was sued and his wages garnished for $300 per month, about 20 percent of his income.

Case Study: Quinton White. A recent *Wall Street Journal* article disclosed that White's wife, Jeanette, an uninsured cleaning woman, was treated for throat cancer in 1982 at Yale-New Haven Hospital in Connecticut. She died in 1993. Over the 20 years since the treatment, Mr. White, now 77 and a retired dry-cleaning worker, had paid $16,000 of the original $18,740 bill. The hospital seized $10,000 from his bank account and placed a lien on his home, imposed a 10 percent interest charge on the unpaid balance, and assessed legal fees and other expenses. By March 2003, Mr. White still owed $39,000.

Once the paper publicized the story and readers expressed their outrage, the hospital decided to forgive the debt in its entirety.

Who Is Affected?

These practices disproportionately affect minorities, who tend to have lower incomes and work for employers who do not provide health insurance. For example, while 11.6 percent of whites were uninsured in 2001, 20.1 percent of blacks and 34.8 percent of Hispanics lacked coverage, according to the Employee Benefit Research Institute.

The *Denver Post* reports, "Almost half of the defendants [being sued by Denver-area hospitals] have recognizable Hispanic surnames."

Can These Practices Be Justified?

Hospitals claim Medicare reimbursements are so low they must shift the costs to other patients. But, as noted above, government figures show hospitals are making, on average, 3.9 percent profit from Medicare in 2003.

Hospitals also claim they don't actually collect the money from the uninsured, because uninsured patients can't pay. But again, state data tell a different story. Many hospitals collect roughly 95 percent of the gross charges they impose on the uninsured—often by using very aggressive collection practices. For example, St. Louise Regional Hospital, cited above, collected 96 percent of what it billed the uninsured. Palm Beach Gardens Hospital, by contrast, collected only 32 percent.

One Solution

One reason this overcharging continues is that it is almost impossible for the uninsured to find out what they will be charged before they receive care.

If hospitals were required to provide patients up front with an estimate of what their gross charges would be, and also with information about what Medicare and the typical HMO plan would pay after discounts, the uninsured at least would have some information to determine whether they wanted to stay at that hospital or go to another.

"After charging the uninsured several times more than an insured person would pay, some hospitals aggressively try to collect the inflated bills."

The media and consumer advocates also would have some basis for informing the public about where to find quality care at a reasonable price. Such a requirement would, in essence, create the kind of price transparency that dominates almost every other sector of the economy.

Randy Suttles is president of Medical Savings Insurance Company. Merrill Matthews, Jr., PhD. is director of the Council for Affordable Health Insurance and assistant editor for Health Care News. *For additional information about their work, contact Tom Gardner, CAHI's director of communications, at 703/836-6200. His email address is* **tgardner@cahi.org**.

Table 2: How Much Do Hospitals Charge Their Patients?

	O'Connor Hospital San Jose, CA	St. Louise Regional (Catholic) W. Gilroy, CA	Palm Beach Gardens Community Hospital (Tenet Healthcare) Palm Beach Gardens, FL
Operating Expense	$1,631.42	$1,376.00	$1,501.37
Collected from Managed Care	$1,940.00	$1,773.00	$1,774.41
Billed the Uninsured	$5,951.00	$5,508.00	$7,414.08
Cost-to-Charge Ratio	.258	.289	.205
Collection Rate from Uninsured	97%	96%	32%

Table 1: Best and Worst Statewide Average Operating Cost-to-Charge Ratios (2002)

Best		Worst	
Maryland	0.759—32% above cost	Nevada	0.282—255% above cost
North Dakota	0.609—64% above cost	California	0.328—205% above cost
Washington	0.581—72% above cost	Alabama	0.338—195% above cost
Vermont	0.580—72% above cost	Florida	0.343—192% above cost
Maine	0.580—72% above cost	Arizona	0.345—190% above cost

Note: To find the percentage the hospital is charging above its cost, enter 1.00, which stands for what the hospital charges, into a calculator. Divide by .759, which is the average statewide cost in Maryland. The answer is 1.32, which means the hospital gets 32% above costs. Nevada has a cost-to-charge ratio of .282. When you divide 1.00 by .282, the answer is 3.55, or 355% of the cost, which means 255% above costs.

Source: Centers for Medicare and Medicaid Services, Table 8A, Federal Register, August 1, 2002.

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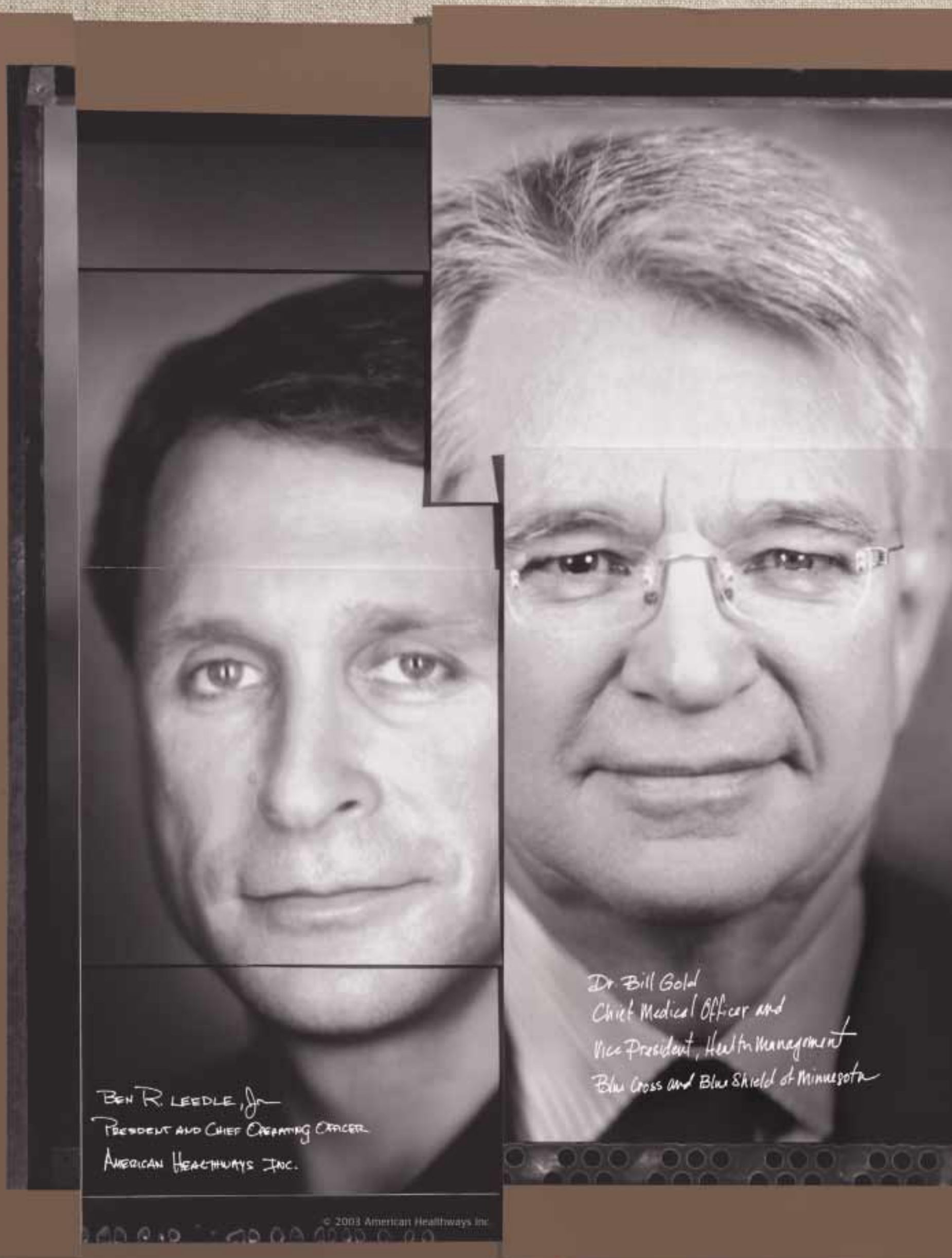
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how many profound effects have you had on the world? i know i've had at least one.

When American Healthways brought me the concept of care enhancement for disease management, the discussion was completely energizing. The optimism was infectious and our thinking just clicked. I could see it, I could taste it—I could feel how profoundly this would affect the future of health care. No one has ever been more ready to sign a contract.

But we had a very diligent skeptic in my organization, and she took the idea to an actuary. Fortunately, instead of finding a flaw, this risk expert got excited too. The numbers checked out and they were incredible. I mean, even if we achieved only half of the plan, we would still astound the world.

Today, thanks to Ben and his team, the program is real, and it's successful. And though we're only a year into a long-term contract, I already see that we've made a huge leap in how a health plan can improve the health of its members. Now it's just a matter of us asking each other, What will we do next? What's possible? How can this partnership affect the world in the decades to come?

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HIV Aid to Africa Will Encounter Obstacles

John R. Graham

HIV/AIDS is mostly a tragedy of the developing world. Forty-two million people are infected with HIV, of which only 1.6 million are in North America, Western Europe, Australia, or New Zealand. Of 5 million newly infected in 2002, only 75,500 are from those developed countries, while 3.5 million were from Africa alone.

Recently, there have been two significant steps in the battle against AIDS in the developing world. First, Congress approved President George W. Bush's request for $15 billion to fund anti-HIV, malaria, and tuberculosis programs for the next five years. This is a big increase in spending and a huge change for a Republican Congress that previously had not been very optimistic about the success of foreign aid.

"HIV/AIDS is mostly a tragedy of the developing world. Forty-two million people are infected with HIV, of which only 1.6 million are in North America, Western Europe, Australia, or New Zealand."

Second, GlaxoSmithKline, the world's largest inventor of drugs to counter HIV/AIDS, announced further price cuts for those drugs that it sells to Africa: from 38 percent to 47 percent off the previously already steep discount.

The President hopes to prevent 7 million new infections (60 percent of the projected new infections in the target countries), treat 2 million HIV-infected people, and care for 10 million HIV-infected individuals and AIDS orphans. A lot of the money will be invested in developing hospitals and satellite clinics to deliver services. Importantly, the President claims he will ensure accountability for results. This is a very important criterion, that, to date, has been lacking in much of the foreign aid to Africa.

Illegal Diversion of Drugs

The lack of good governance in health care systems has resulted in a huge diversion of medicines from sub-Saharan Africa back to Europe, where they are sold for much higher prices. Last year, Belgian customs authorities found that at least three million doses of GlaxoSmithKline's Combivir (zidovudine), scheduled for sale in Africa at about €0.80 per dose, had found their way onto European pharmacists' shelves, where they sold for about €6.00 per dose. Quantities of GlaxoSmithKline's antiretroviral drugs Epivir (lamivudine) and Trizivir (abacavir) also have been illegally diverted back to Europe.

The drugs were supposed to go to HIV/AIDS clinics in Senegal, the Ivory Coast, the Republic of Congo, Togo, and Guinea-Bissau. An estimated 28 shipments, with a retail value of €29m, came back to Antwerp through Paris and Brussels. A spokesman for GlaxoSmithKline estimated that about a quarter of the drugs it had exported to Africa had come back to Europe.

This makes Glaxo's offer of a further price cut remarkable. Why do brand name companies offer their drugs at a discount in sub-Saharan Africa at all, if unethical traders simply ship those drugs back to Europe, denying them to Africans and cutting the manufacturers' profits in Europe?

Unfortunately, some lesser-developed countries prefer bullying, rather than negotiation, as a tactic to get the medicines their residents need. They have threatened to disregard patents and allow generic manufacturers to compete against the companies that invented the medicines.

Presumably, brand name drug makers figure that having their own drugs diverted to higher-priced markets is the lesser of two evils. At least when they ship their own drugs, they have some influence over their distribution in the target country. If they completely abandoned those countries to generic competitors, they would have no idea if those generic drugs were being relabeled and exported to European countries where the prices for them would be higher. As well, the willingness of European customs authorities to confiscate medicines that are inappropriately diverted back to Europe must give the manufacturers some comfort.

Holding Hospitals Accountable

If some of the new U.S. money will develop good governance of African health care systems that prevent these shenanigans, it will be money well spent. However, the idea of the U.S. government "holding accountable" hospitals and clinics in Africa tends to stretch credulity. Even at home, the U.S. government does not have a good track record at regulating hospitals. Increasing regulation of U.S. hospitals has led to collusion and barriers to building new ones.

Furthermore, new research indicates that hospitals and clinics may be part of the problem in Africa, rather than the solution. In a series of three articles, a group of scientists recently challenged the consensus that 90 percent of HIV infections in Africa were caused by sexual contact. This belief always has been a bit of a puzzle, because heterosexual transmission is not a big factor in developed countries.

The researchers note the "sexual" consensus emerged in 1988 and has subsequently suppressed inquiry and dissent. In a literature review, they claim that medical transmission of the virus—that is, through re-using needles in health facilities—led to 48 percent of HIV infections through 1988, when the "sexual" consensus emerged. Currently, they estimate that only 25 to 35 percent of the

HIV incidence in Africa is attributable to sexual transmission. Although most experts still hold that unsafe sex is the main mode of transmission, this new research demonstrates uncertainty about what is causing the AIDS epidemic in Africa.

At best, we should probably be cautiously optimistic about Bush's ability to achieve his stated goals with $15 billion of his taxpayers' money. The obstacles to success are many, and money alone will not address them.

John R. Graham is director of pharmaceutical policy research at The Fraser Institute. His email address is **johng@fraserinstitute.ca**. *A longer version of this article, including references, was published in the June 2003 issue of* Fraser Forum, *available online at* **http://www.fraserinstitute.ca**.

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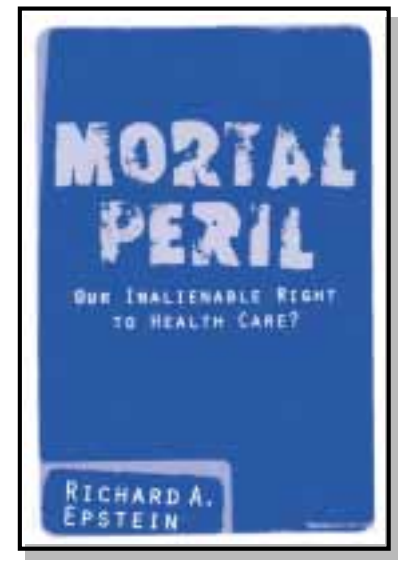

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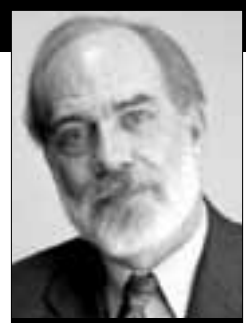


Greg Scandlen

The Physician as Small Business Owner

I testified before the House Small Business Committee, chaired by Congressman Donald Manzullo (R-Illinois), at a hearing on physicians as small business owners.

This was a field hearing held in Frederick, Maryland to get the ideas of members of the local community. Our local Congressman, Roscoe Bartlett (R-Maryland), was there, as was Congresswoman Donna Christensen (D-Virginia). The hearing was not about any particular legislation, but about the problems physicians face in maintaining their independent practices.

Witnesses included Dr. and Mrs. Camilo Toro of Frederick Neurology; Dr. Michelle Davis of the National Medical Association; Dr. Jim Pendleton of the Pennsylvania chapter of the Association of American Physicians and Surgeons (AAPS); Elizabeth Chung, a Frederick practice administrator; Dr. Christopher Unger of Bethesda; William Sarraille, a local attorney; and Linwood Rayford of the Small Business Administration.

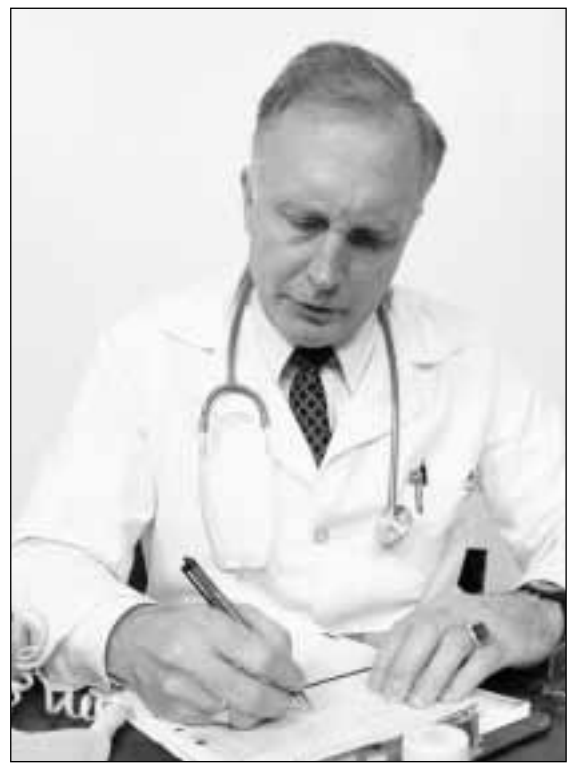
Among the material handed out by the committee were two articles published by the Objectivist Center—one by Madeleine Cosman called "The Government's Envy Engine," and the other by Edward Hudgins titled "Doctors Shrug." Cosman's article looks at the (mis)use of *qui tam* ("whistleblower") actions against physicians. She cites some horrendous examples of doctors being fined huge sums and sent to jail for what amount to billing errors or differences in medical judgment.

Hudgins argues we are beginning to see a replay of *Atlas Shrugged* in medicine, where the best and the brightest are refusing to continue to play the game.

My own testimony emphasized what virtually every physician will agree are the big problems: inadequate reimbursement, excessive regulation, administrative overload, and a tort system out of control.

I suggested to the committee that, instead of trying to fix these issues directly (which could be un-fixed by the next Congress), they should work on changing the underlying dynamics of our system by allowing patients to control their own resources. This would reduce the need for regulation, increase the income of better physicians (but not the mediocre ones), lower administrative burdens, and reduce the impulse to sue for medical problems.

Committee members were surprisingly savvy about these issues. They had already identified excessive reliance on third-party payment as the core problem, and were very interested in empowering health care consumers. *The Committee will be posting the testimony on its Web site at:* **http://www.house.gov/smbiz/**. *My statement may be found at* **http://www.galen.org/news/Small_Business.pdf**. *The two Objectivist Center papers may be found at* **http://www.ObjectivistCenter.org**.



Reimportation: Latest Hot Topic in Washington

There has been a real split among conservative/libertarian types over the issue of "reimporting" prescription drugs from Canada and other price-controlled countries.

One side argues free markets demand people be free to buy stuff wherever it is cheapest. The other side counters free markets also demand respect for property rights.

Price controls amount to a confiscation of intellectual property—especially when there is a hidden threat by a foreign government to violate patent rights. In the course of these debates, I realized I knew very little about how Canada's price controls actually work. But Chris Middleton of the Pacific Research Institute came to my rescue with an excellent description from *Health Affairs* written by Devidas Menon, CEO of Alberta's Institute for Health Economics.

Source: This is a fee-based subscription site. **http://www.healthaffairs.org/1130_abstract_c.php?ID=/usr/local/apache/sites/healthaffairs.org/htdocs/Library/v20n3/s13.pdf**

High-Deductible Plans Attractive in Kansas City

After all the contention and emotion surrounding the great debates in Washington, it is refreshing to get out of the Beltway and remember that in the real world people do more than just argue.

For instance, Karen Uhlenhuth writes in the *Kansas City Star* about the Scott Lewis family, who decided to forego paying $1,200 to $1,300 a month for HMO coverage and opted instead to pay $500/month for a $5,000 deductible policy. "He goes to any doctor he wishes. He doesn't need permission for any procedure or to see any specialist. (His) health plan is refreshingly simple—and cheap."

While individuals have always been able to purchase coverage like this, the article notes, "employers are starting to offer this option." It cites several local companies where as many as 30 percent of the workers have opted for consumer-driven health plans.

The article also cites a local physician who has decided to convert her practice to a cash-only basis; SimpleCare is mentioned as an example of a growing trend. The article quotes Devon Herrick of the National Center for Policy Analysis, Larry Akey of the Health Insurance Association of America, and Vivius founder Howard Wizig.

Source: **http://www.kansascity.com/mld/kansascitystar/living/6265408.htm**.

To learn more about SimpleCare, go to **http://www.simplecare.com**

Risk-Based Ratings

The Detroit News published an article by Lynn Waldsmith, who looks at consumer-driven health from a different angle. The article asks, "Why should a thin health-conscious worker pay the same premium as his 320-pound, smoking co-worker?"

Such issues, Waldsmith writes, are helping to fuel the move to consumer-driven care, in "an effort to get people to take more responsibility for their health." The article explores the pros and cons of risk-based rating, especially in the areas of smoking and obesity.

Source: **http://www.detnews.com/2003/editorial/0307/13/a13-215602.htm**

Consumerism Works for Public Programs, Too

Writing in the *Milwaukee Journal Sentinel*, John Torinus notes, "The principles of consumer-driven health care are spreading quickly across private-sector health plans," and he calls for similar expectations "for personal responsibility (to be) built into public-sector health plans." Torinus says medical costs consume 25 percent of the Wisconsin state budget and are rising at a rate of 15 percent or more per year.

"Public employees have a huge stake in getting this monster under control because they are sacrificing take-home pay for keeping their ill-designed medical packages in place," he notes.

Source: **http://www.jsonline.com/bym/News/jul03/154555.asp**

Wisconsin Employers Embracing CDHC

Also in the *Journal Sentinel* is an article by Joe Manning, who asks, "When was the last time you asked your doctor how much a procedure or treatment would cost? Probably never. But that could change soon with the dawning of CDHC."

Manning predicts a "major shift" in the health insurance industry, but also notes "the concept has its critics." These include "Dirk Carson, an executive with Patient Choice, a Minnesota-based health insurer attempting to enter the Wisconsin market," who says, "The idea just throws people to the wolves."

The rest of the article is largely favorable and includes the experience of a number of local employers who are moving in the consumer-driven direction. Robert H. Booz, who authored a study for Conning Research & Consulting, says, "CDHC market penetration could be as great as 50 percent within the next five years," according to the article.

Source: **http://www.jsonline.com/bym/News/jul03/153481.asp**

Defined Contribution, the "Next Dominant Form"

The Wharton School has jointly issued a paper with Booz Allen Hamilton, titled, "Consumer Take Charge: Defined Contribution Health Plans." The paper says "2003 may be the year that defined contribution plans begin to make their mark as the most influential new form of health insurance coverage since managed care."

Booz Allen's Gary Ahlquist says, "Defined contribution plans won't be the final form of American health care, but they will be the next dominant form." Wharton's Mark Pauly says, "(these plans represent) a lot of risk for people to take on. Still, people feel more capable of handling their own health care rationing today than they did before."

Source: **http://www.strategy-business.com/article/?art=47325691&ps=pHwXw0**

Greg Scandlen is director of the Galen Institute's Center for Consumer Driven Health Care and assistant editor of Health Care News. *His email address is* **gmscan@aol.com**.

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Who is Dr. Merrill Matthews?

Merrill Matthews Jr., Ph.D., is a Heartland Senior Fellow specializing in health care policy and director of The Council for Affordable Health Insurance. Dr. Matthews is past president of the Health Economics Roundtable for the National Association for Business Economics, the largest trade association of business economists, and health policy advisor to the American Legislative Exchange Council, a bipartisan association of state legislators.

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Georgia

Continued from page 1

as the next hot market, ripe for managed care, Medicaid-style.

Managed Care Comes to Medicaid
"Everything is on the table right now and worth some consideration," said Tim Burgess, commissioner of the state's Department of Community Health (DCH).

According to DCH records, the cost of the state's Medicaid program rose 16 percent between 2001 and 2002, while enrollment increased only 7 percent. The program's costs—expected to reach more than $1 billion in 2004—have consistently outpaced the tax revenues allocated to it.

First-term Governor Sonny Perdue (R), faced with making deep and unpopular budget cuts as tax revenues come up short, has requested a new approach to fixing the health care entitlement plan.

Part of the solution, according to an Associated Press report, will likely be a new managed care system for some Medicaid recipients.

Many states have turned to managed care in combination with or as a replacement for the fee-for-service model that has characterized Medicaid in the past. Managed care offers potential for cost containment, although at the price of limiting patient choices and requiring a larger bureaucracy to monitor and restrict access to care.

Georgia is the tenth most populous state in the country, with both urban and rural areas. With a robust and competitive private-sector health care market already in place, the state could be prime territory for managed care, analysts say. "Its pure size" makes the state attractive for managed care, said former insurance regulator Brent Layton of consulting firm Layton & Associates. "When you have a large state with a large Medicaid population, any company would be interested in Georgia."

How it Works
Instead of fee-for-service benefits, Medicaid recipients under a managed care model are directed toward a specific network of doctors and hospitals and, as is the case with consumers in the non-Medicaid population, must comply with various deductibles, co-payments, restrictions on treatment options, and prescription drug formularies.

Such change does not come easy for Medicaid stakeholders. "The transition from more traditional Medicaid to managed-care Medicaid has always had rough spots," said Dr. William Custer, a health care policy expert at Georgia State University. "It's a shift for providers, it's a shift for enrollees and for the state, and any transition has rough spots."

Custer also noted Medicaid recipients present unique challenges not present in the standard health insurance market. Less easy access to transportation and a lower level of education are among those challenges.

"Georgia has an advantage in that companies getting into this [Medicaid managed care] business today understand it better and there are lessons to be learned from the experiences of other states that have made the transition," Custer said.

Georgia Governor Sonny Perdue (R)

According to a report published by the *Atlanta Business Chronicle*, California-based Molina Healthcare Inc., AmeriChoice Health Services Inc., Virginia-based Amerigroup Corp., AmeriHealth Mercy Health Plan, APS Healthcare Inc., Centene Corp., Evercare, and WellPoint Health Networks Inc. have all presented reorganization plans to the state.

WellPoint, the parent company of Blue Cross and Blue Shield of Georgia, offered to run a pilot Medicaid managed care program for the state while the proposals were being reviewed. That offer was rejected, however, because obtaining the required federal waivers from the Centers for Medicare and Medicaid Services would have been time-consuming, according to a statement issued by Blue Cross spokesman Charlie Harman. WellPoint's state Medicaid HMO business includes more than 1 million members in the United States and 580,000 members in Puerto Rico.

Package Deal
Ultimately, the state will need a mix of programs, including long-term care options and disease management to help with prescription drug cost containment. (See "Florida Renews Disease Management Program," *Health Care News*, August 2003.)

More than half of the companies and organizations responding to the state's request for proposals—including Amedisys, one of the country's largest home health nursing care providers—operate in these niche areas.

According to a DCH spokesperson, a team from the department will review all proposals and recommendations before bringing them before the state Office of Planning and Budget, and ultimately to Governor Perdue. Once a model has been chosen for the state, a new request will be issued and vendors selected by next summer.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Hard Lesson about Socialized Medicine

Managing Editor's note: "Those who cannot learn from history are doomed to repeat it," said George Santayana. Given this article was first published on September 23, 1996, it appears politicians on both sides of the aisle have been cutting history class for at least seven years.

Michael Tanner

Europeans are now learning some hard facts of life about socialized medicine: There's no such thing as a free lunch. The question is whether Congress will learn from Europe's mistakes as it takes the next steps in reforming the American health care system.

For many years advocates of government-run health care pointed to Europe as an ideal, noting America was the "only industrialized country without a national health care system." Now, however, the European welfare states are slashing benefits in the face of rising health care costs.

A recent front-page story in the *New York Times* detailed the European cutbacks. According to the article, Britain, France, and Germany are all being forced to limit access to care. Rationing, already extensive, is increasing.

The Europeans have run into a very simple economic rule. If something is perceived as free, people will consume more of it than they would if they had to pay for it. Think of it this way: If food were free, would you eat hamburger or steak?

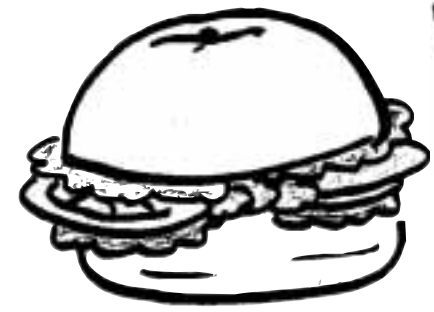
At the same time, health care is a finite good. There are only so many doctors, so many hospital beds, and so much technology. If people over-consume those resources, it drives up the cost of health care.

The same problem is besetting the American health care system. The vast majority of American health care is not directly paid for by the person consuming those goods and services. Instead, a third party, either the government or an insurance company, pays the bill.

Exhibit One

Medicare is exhibit one. Medicare beneficiaries pay almost nothing out of their own pockets for health care. Under Medicare Part B, for example, the deductible is an absurdly low $100. (There is, however, a 20 percent co-payment.) The deductible under Part A is higher, $716 on the first 60 days of hospital care for each spell of illness. There is also a co-payment required for hospitalization of longer than 60 days

Nearly 70 percent of the elderly have some form of "medigap" insurance that covers all or part of the deductibles and co-payments. Thus, Medicare recipients have little incentive to be good consumers, avoid unnecessary expenses, or seek the best deal for their dollar. Guy King, former chief actuary for the Health Care Financing Administration, says third-party payment is one of the primary causes of the rapid growth in Medicare expenditures. As King explains, "When people, either patients or doctors, are spending other people's money, they do not worry about the cost or number of services consumed."



If food were free, would you eat hamburger or steak?

The establishment has responded to this problem by trying to force seniors into managed care, thereby allowing insurance companies to ration care. But managed care does not change the underlying incentive structure created by pervasive third-party payment. Any reduction in costs is achieved by limiting access to treatment.

Rationing, Low-Quality Care

A report by the Department of Health and Human Services' inspector general found "pervasive" quality problems throughout managed care programs for Medicare, including difficulties in gaining access to care. Managed care programs are significantly less likely to use diagnostic tests, such as MRI and CAT scans, than are fee-for-service plans.

Doctors report managed care organizations pressure them to save money even at the cost of quality. One-third of doctors surveyed by the American Medical Association in 1988 said patients were harmed by delays or non-treatment as a result of managed care.

Although the election season has temporarily taken Medicare off the table, the issue will be back to haunt the President and Congress next year. Indeed, the most recent report of the Medicare system's Board of Trustees warns that the program faces bankruptcy in just five years.

The question is whether we will recognize the problems of third-party payment and restore consumer incentives by increasing deductibles and allowing recipients to choose medical savings accounts, or follow the European example and ration the health care that our seniors depend on.

For years we've been told to look to Europe for lessons about health care. This time, maybe we should.

Michael Tanner is director of health and welfare studies at the Cato Institute. His email address is **mtanner@cato.org**.

Edwards

Continued from page 1

The Edwards proposal provides for tax credits to help families purchase coverage for their children through employer-sponsored health insurance plans or the State Children's Health Insurance Program (SCHIP).

Edwards said his proposal would allow parents to enroll their children in health insurance programs at hospitals after birth, on the first day of school, and on tax returns. Parents who failed to enroll their children in a health insurance program would receive an "initial warning." If parents failed to respond by getting health insurance for their children, the federal government would enroll the children in "the appropriate program" and effectively bill the family through taxes.

"Children don't raise themselves," Edwards said. "That's what parents do. Parents must take responsibility to enroll their child in a health care plan, and America will make sure they can afford it."

Twila Brase, a registered nurse and president of the Minneapolis, Minnesota-based Citizens Council on Health Care (CCHC), took exception to the senator's approach. "Senator Edwards contradicts himself. He says raising children is the parent's responsibility, but his proposal declares child-rearing to be the government's responsibility.

"This should concern parents everywhere," she continued. "If government can require parents to buy insurance, what's to keep government from developing a full set of required parental duties?"

Uninsured Adults Also Addressed

Edwards said his plan for addressing the nation's uninsured problem also would allow adults age 55 and older, and their spouses even if younger, to purchase health coverage through Medicare.

Insurance companies also would be required to subsidize coverage for workers with employer-provided coverage who become unemployed.

Edwards said his proposal would provide health coverage to an estimated 12 million uninsured residents younger than age 21 and to 8 million uninsured adults.

Paying the Price

Edwards said he would repeal tax cuts enacted by President George W. Bush and reduce the size of the federal government to cover the cost of his proposal.

Requesting anonymity, a spokesperson for the Edwards for President campaign told *Health Care News* the proposal includes provisions they say would reduce federal health care expenditures by an estimated $17 billion per year by limiting prescription drug advertising.

Further savings from the development of electronic medical records and payment systems and reductions in the number of medical malpractice lawsuits filed would, Edwards asserts, help pay for the plan, but no details have been offered.

Reaction

Chris Conover, a professor at Duke University who specializes in health care for low-income patients, questioned the cost-effectiveness of the Edwards proposal. He noted health care costs for children are lower than costs for adults, who require more treatment.

"I understand politically the appeal of covering kids," said Conover, "but from the raw, bang-for-the-buck point of view, it's not the most logical place to start filling in the gaps of coverage."

"We have Medicaid for poor children and S-CHIP for low-income children," added Merrill Matthews Jr., Ph.D., director of the Council for Affordable Health Insurance. "Now Sen. Edwards wants to tax middle-class taxpayers to create a government program for middle-class children. And if the parents choose not to take the program, they will get taxed yet again as punishment. All the while, the media will complain that middle-income families don't have enough money to buy health insurance."

According to the *Raleigh News & Observer*, officials in the Edwards campaign expected the proposal to attract criticism as an "intrusion in parenting decisions."

CCHC's Brase certainly feels that way. "Mandates force citizens to buy products they may not want, no matter how high the price. Higher prices then invite government intervention and intrusion.

"It's up to health insurers to make a product that consumers want," Brase said. "And until government gets out of the way, insurers won't even try."

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INTERNET INFO

For more information about the Citizens Council on Health Care, visit its Web site at **http://www.cchc-mn.org/**.

For more information about the Council for Affordable Health Insurance, go to **http://www.cahi.org**.

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Exempt

Continued from page 1

Daniel C. Adcock, assistant legislative director of the National Association of Retired Federal Employees, explained, "Our members fear the government will be tempted to reduce or eliminate drug coverage for federal retirees, in favor of a Medicare plan that would be inferior and more complex."

Separate and Not Equal

The House and Senate bills to protect current and future federal retirees were introduced in late June by Rep. Tom Davis (R-Virginia) and Sen. Daniel K. Akaka (D-Hawaii). The bills also require the value of drug benefits offered to federal retirees be "at least equal to" the value of drug benefits offered to current federal workers.

Federal workers and retirees receive drug benefits through the Federal Employees Health Benefits Program (FEHBP), repeatedly cited by President George W. Bush and members of Congress as a model for Medicare. Nevertheless, the FEHBP drug benefit is significantly more generous than drug benefits described in Medicare reform plans passed in July by the Senate and the House.

"In the case of the Medicare drug benefit, one clear message coming out of Congress is this: Government-run medicine might be OK for all the little people, but not for us thank you very much."

Robert E. Moffit
The Heritage Foundation

Akaka said his proposal would preserve today's level of drug coverage for federal retirees and added, "[Federal employees] should not face a situation in which they must rely on Medicare."

Davis said the federal government should set an example for private employers to discourage them from dropping the drug benefits they already provide to retirees.

According to the *New York Times*, David Marin, a spokesman for Davis, said, "This is not about members of Congress protecting their own interests. It's about protecting the interests of retirees."

Robert E. Moffit PhD, director of the Center for Health Policy Studies at The Heritage Foundation, thinks otherwise. "That tells you a lot about the value of the proposed drug benefit," he noted.

Fear of Falling Benefits

The Medicare reform legislation currently under negotiation authorizes the largest expansion of benefits since the health insurance program was established in 1965. Unless major revisions are made in the conference committee, analysts say Medicare reform will offer private and public employers a powerful incentive to curtail or even drop drug benefits for their retirees.

The Congressional Budget Office estimated one-third of retired employees with employer-sponsored drug coverage could lose their private benefit as a result of Medicare reform legislation.

Roughly 8.5 million federal workers, retirees, and relatives—including most lawmakers and the President—are covered by the federal employee health plan, Many worry Congress or the U.S. Office of Personnel Management would attempt to save money by reducing retiree drug benefits, knowing the federal retirees could simply go into the Medicare program.

The most popular FEHBP plan among federal workers is the Blue Cross and Blue Shield standard option. The Congressional Research Service estimates the drug benefits under that plan are worth about 50 percent more than the proposed Medicare drug benefits.

According to an analysis by Kenneth E. Thorpe, chairman of the health policy department at Emory University's Rollins School of Public Health, the Blue Cross plan covers 80 percent of total drug costs, compared with about 49 percent in the Senate version and 55 percent under the House version. Thorpe estimated it would cost $300 billion more over 10 years to bring the $400 billion Medicare proposal up to the level of federal employee benefits.

All 188 plan options within the FEHBP include drug coverage valued at substantially more than the two Medicare reform bills. Under the Blue Cross plan, employees do not pay an additional premium or deductible for drug coverage, while both Medicare measures require an annual contribution of $420 and a deductible of at least $250.

Medicare beneficiaries who buy separate prescription drug insurance would, for example, pay higher co-payments and premiums than federal retirees typically pay. Medicare patients would have to pay all drug costs from $4,501 to $5,813 a year in the Senate bill or from $2,001 to $4,900 in the House version. Such lapses in benefits do not exist in the plans available to federal retirees.

Adcock said any cut in drug coverage for federal retirees would break the bargain under which they worked. "The bottom line," he added, "is that this is an earned benefit—deferred compensation, no different from retirement income.

"Federal employees generally don't earn as much as private-sector workers, but they make that sacrifice for the peace of mind of knowing they will have health coverage in retirement."

Bush has suggested Medicare beneficiaries should not accept less than what lawmakers receive. Earlier this year and numerous times since, Bush said, "If it's good enough for the Congress, it's good enough for the senior citizens of America."

Crippled Competition

According to Heritage Foundation analysts Edmund F. Haislmaier, Robert E. Moffit, and Nina Owcharenko, "The administration says the congressional Medicare legislation creating the 'Medicare Advantage' system will offer a variety of plans 'modeled after' the Federal Employees Health Benefits Program."

Moffit explained to *Health Care News*, "Rep. Bill Thomas (R-California) and most of his colleagues on the House Ways and Means Committee do favor that model for Medicare. In the House bill, there is a provision that would begin Medicare's transition to the FEHBP-style Medicare program but not until 2010."

But, Moffit added, "196 members of the House of Representatives are on record opposing that transition to an FEHBP-like system, and 37 senators say that a transition to a competitive system is unacceptable in any final bill.

"In other words, they're enrolled in a superior health plan, with reliable drug coverage, whose replication for the retiring baby boomers they steadfastly oppose."

Unlike the House measure, the Senate reform bill outlines a "Medicare Advantage" system very different from the FEHBP, which is a system of mostly fee-for-service or preferred provider (PPO) health plans. All FEHBP plans compete for consumers across the country, and about 70 percent of all FEHBP enrollees are in national fee-for-service or PPO plans. The Senate's "Medicare Advantage" program offers no national plan.

In lieu of competition, the Senate measure authorizes the administrator of a proposed Center for Medicare Choice to divide the nation into 10 or more regions, not unlike the health care regions promoted by former President Bill Clinton in his failed Health Security Act. The PPO option outlined by the Senate is restricted to the three cheapest plans in any given region.

In other words, according to the Heritage Foundation analysts, Medicare becomes a government-sponsored oligopoly "in which Medicare beneficiaries [seeking a PPO option] would only be allowed to choose [from among] three plans. This is not a model based on normal market forces of consumer choice and competition; it is instead a dramatic deviation from the FEHBP model, where many plans compete for consumers' dollars."

"In the case of the Medicare drug benefit," Moffit noted, "one clear message coming out of Congress is this: Government-run medicine might be OK for all the little people, but not for us thank you very much."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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GALEN INSTITUTE | A MONTHLY REVIEW OF HEALTH POLICY MATTERS

Grace-Marie Turner

President George W. Bush has weighed in on reimportation of drugs, calling the initiative "dangerous" because it "would create serious drug safety problems ... allowing counterfeit, adulterated, inactive, and unapproved drugs to enter the country," with the potential for injuring public health and threatening the security of the nation's drug supply.

FDA Commissioner Mark McClellan sent a strongly worded letter to the chairman of the House Energy and Commerce Committee, Billy Tauzin (R-Louisiana). McClellan said the bill would erode the FDA's ability to oversee the nation's drug supply. He also noted requiring pharmaceutical companies to institute anti-counterfeiting measures would increase drug costs by $2 billion.

The Congressional Budget Office chimed in as well, saying drug reimportation would not reduce drug costs to American consumers.

Many conservatives have argued allowing Americans to buy drugs more cheaply abroad is free trade. But it's hardly free trade when you are importing price controls from countries with socialized health care systems that impose global budgets and ration medical care—including prescription medicines.

Then they argue drug companies should just refuse to sell their products to countries that don't agree to a fair price, one that includes a share of the R&D costs. House Judiciary Committee member Chris Cannon (R-Utah) says that is seldom an option. "The patent laws of almost every country in the world allow the government to confiscate or 'compulsory license' a company's patent if it is not 'worked' locally," he wrote in a Dear Colleague letter.

That means if a drug company doesn't agree to the prices a government demands, the country will essentially steal the patent. What kind of a choice is this for companies whose most valuable asset is their intellectual property?

When Representative Gil Gutknecht (R-Minnesota) lobbies for his reimportation bill, he circulates a chart comparing the prices of 16 drugs in the U.S., Canada, and Europe. Not surprisingly, every one is cheaper elsewhere—because other countries don't pay their fair share of the research and development costs.

One enterprising researcher produced another chart showing where those drugs were developed: 11 in the United States, five in Europe, and 0 in Canada. Where will the new drugs come from if the U.S. slaps price controls on its drug supply, either directly or indirectly by allowing Americans to import price-controlled drugs?

Representative Jo Ann Emerson (R-Missouri) may be allowed to present a substitute amendment allowing reimportation initially only from Canada, not all 26 countries allowed in the Gutknecht bill. But Emerson proposes a dangerous provision that would tell drug companies they must sell their products to American consumers at the lowest price they offer anywhere in the world.

Grace-Marie Turner

RECENT ARTICLES & STUDIES

Prescription Drug Reimportation Debate

Stephen Entin (Institute for Research on the Economics of Taxation) says reimportation would reduce incentives for pharmaceutical companies to develop new medicines, "denying new and improved treatments to tens of millions of future patients, resulting in earlier death and reduced quality of life."
Source: **http://www.iret.org**

Sally Pipes (Pacific Research Institute) says pharmaceutical companies can afford to sell drugs below the average production costs for some countries, but not for everyone. Pipes says a reimportation measure will restrict the supply of drugs in the price-controlling countries from which Americans are likely to reimport drugs. "Canadian pharmacists will be forced to make a choice: send the pharmaceuticals south for a quick profit or sell them at home," she writes. "If it's the latter, they'll be doing the most unnatural of acts: forgoing their personal economic interest. If they do the former, Canadians will find themselves heading south for more expensive, but at least available, drugs, just as they now do for high-tech medicine."
Source: **http://www.pacificresearch.org/press/opd/2003/opd_03-07-23sp.html**

"Price discrimination is a way of making products available to people who otherwise could not afford them," says John Goodman of the National Center for Policy Analysis.
Source: **http://www.washtimes.com/commentary/20030720-103239-6685r.htm**

For Tech Central Station, James Glassman and John Lott explain the free rider phenomenon and conclude Canada and Europe should be the strongest opponents of U.S. prescription drug reimportation.
Source: **http://www.aei.org/news/newsID.18078,filter./news_detail.asp**

David Kendall (Progressive Policy Institute) says price controls would "undermine a competitive approach for delivering a Medicare drug benefit." Instead, he notes, "public policy should strengthen the ability of private markets to restrain prices."
Source: **www.ppionline.org/ppi_ci.cfm?knlgAreaID=111&subsecID=141&contentID=251891**

Cost Estimate for H.R. 1 and S. 1, Medicare Prescription Drug Acts

Congressional Budget Office
July 22, 2003

The Congressional Budget Office estimates the House and Senate Medicare bills would each cost more than $400 billion. According to the report, the Senate bill would cost $461 billion in direct spending over 10 years, while the House bill would cost $408 billion.

The CBO also says enrollment in private health plans, a central goal of both bills, would be lower in a decade than it is today: 11 percent of Medicare beneficiaries would likely sign up for some type of private health plan under the House bill; 9 percent would sign up under the Senate bill. Currently, 13 percent of Medicare beneficiaries obtain care through HMOs and other private health plans.

The CBO also concludes prescription drug reimportation provisions contained in the two bills "would probably not produce substantial savings to the federal government. ... Manufacturers of brand-name drugs are unlikely to increase their sales in Canada enough to permit a significant share of their United States market to be imported from Canada. ... If manufacturers were unable to limit the supply of drugs entering the U.S. market from Canada, the likely result would be that brand-name drug prices in Canada would rise much more than the price in the U.S. would decline."
Full text (pdf): **ftp.cbo.gov/44xx/doc4438/hr1s1.pdf**

Prescription Drug Benefit: Is it Good for Seniors?

House Government Reform Subcommittee on Human Rights and Wellness
July 17, 2003

"The Medicare prescription drug benefit advancing through Congress will cost much more, and do less good, than many legislators realize," testified Joe Antos of the American Enterprise Institute at a hearing before the House Subcommittee on Human Rights and Wellness. "Rather than trying to control the costs of individual health services, as Medicare has tried unsuccessfully to do over the past three decades, we should integrate prescription drugs with all other benefits," said Antos. "Our proper concern should be on the overall growth in health spending."

Edmund Haislmaier of The Heritage Foundation testified, "employers who currently offer prescription drug coverage for their retirees will either scale back their coverage to the standard plan design or replace their existing coverage with wrap-around coverage." Helen Darling of the Washington Business Group on Health, Donald Newcomb of the Alliance for Retired Americans, and Gail Shearer of Consumers Union also provided testimony.
Full text of all testimony: **www.house.gov/burton/71703h.htm**

Material for this report is provided by The Galen Institute, P.O. Box 19080, Alexandria, VA 22320, **www.galen.org**. *Grace-Marie Turner is president. The report was produced by Elizabeth Lamirand, who can be reached at 703/299-9550, and edited by Conrad F. Meier, managing editor of* Health Care News.

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CDHCC Announces Fall Program for Nashville

Leanne Forbes

On November 10-12, 2003, The Emergent Group will convene health care executives and senior decision makers from the employer community to discuss the health care consumer phenomenon and the future of health care delivery at the Consumer Directed Health Care Conference and Expo (CDHCC).

CDHCC will share keynote presentations and a common exhibition floor with the Healthcare Delivery Solutions Congress, combining to offer more than 200 speakers who will address their respective targeted communities in more than 100 concurrent sessions.

The CDHCC program will offer distinct pre-conference tracks aimed at the employer, provider, health plan, and agent/broker communities, and one track for participants interested in government plans and pending legislation. Conference tracks will be aimed at the employer, provider, and health plan communities, plus direct-to-consumer (DTC)/mature markets and digital health/telemedicine.

Confirmed Speakers

More than three dozen feature and keynote speakers already have confirmed for the event. Among them are several experts familiar to *Health Care News* readers, including Jack Faris, president and CEO of the National Federation of Independent Business; former Congressman Newt Gingrich, founder of the Center for Health Transformation; James Rodgers of the American Medical Association; and Greg Scandlen, director of the Galen Institute's Center for Consumer Driven Health Care and author of the "Consumer Choice Matters" column in *Health Care News*. (See page 13.)

Member Rewards

CDHCC members receive event discounts and other benefits. Member benefits include:

- 10 percent discount on all The Emergent Group conferences. (Cannot be combined with any other discount.)
- free newsletter
- weekly updates on conferences and trade shows.

To become a member of CDHCC, visit **http://www.cdhcc.com**. You must use a valid email address to become a member.

The Emergent Group, LLC

The Emergent Group, LLC is an event management company offering a full range of management services and partnership opportunities. The company brings years of knowledge and experience to a variety of industries, including health care, media, travel, financial, entertainment and sports, and produces several industry-specific events including Consumer Directed Healthcare Conference (CDHCC), Healthcare Delivery Solutions Congress (HDSC), and The Emerging Technologies and Healthcare Innovations Congress (TETHIC).

Leanne Forbes is with The Emergent Group. Her email address is **leanne@theemergentgroup.com**.

INTERNET INFO

For more information about the November CDHCC, visit **http://www.cdhcc.com**. For more information about event managers The Emergent Group, visit **http://www.theemergentgroup.com**.

Other confirmed speakers for the event include:

- **Pam Bailey**, president, Advamed
- **Stan Bernard**, president, Bernard Associates
- **Jon Comola**, president, Wye River Group on Healthcare
- **Joe Coughlin**, MIT AgeLab
- **John Davies**, vice president and general manager of Intel Corporation's Solutions Group
- **Nancy-Anne DeParle**, senior advisor, JP Morgan
- **Raymond Falci**, health care analyst, Bear Stearns
- **Frank Houser**, MD, Chief Medical Officer, HCA Inc.
- **Jeff Gelfand**, MD, Massachusetts General Hospital/Center for Integration of Medicine & Innovative Technology
- **Jeff Goldsmith**, president, Health Future, Inc
- **Harry Jacobson**, MD, vice chancellor for health affairs, Vanderbilt University Medical Center
- **Doug Kronenburg**, chief strategy officer, Lumenos
- **Charles N. Kahn, III**, president, Federation of American Hospitals
- **Ken Linde**, CEO, Destiny Health
- **Robert Margolis**, MD, CEO, Healthcare Partners
- **Tom Miller**, president, Siemens Medical Solutions
- **Tony Miller**, CEO, Definity Health
- **Frank Morgan**, analyst, Jeffries & Company, Inc.
- **Lee Newcomer**, CEO, Vivius
- **James Nuckolls**, MD, medical director, Carilion Healthcare Corporation
- **Neal Patterson**, chairman and CEO, Cerner Corporation
- **Kip Perlstein**, vice president and national practice leader, Cap Gemini Ernst & Young
- **Lori Price**, health care services analyst, JP Morgan
- **Richard Reece**, MD, editor-in-chief, *Practice Options*, Premier Health Resource, Inc.
- **Jack Reed**, president and CEO, ProHealth Physicians
- **Russ Ricci**, MD, chairman of the board, US Wellness; chairman of the board, eHealth Initiative
- **Jill Rotenberg**, JWCH/Coordinated Prevention Network
- **Michael A. Sachs**, president and CEO, SG-2
- **Paul Schyve**, MD, senior vice president, Joint Commission on Accreditation of Healthcare Organizations
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Demonizing Trans Fats

Dr. Elizabeth M. Whelan

When the Food & Drug Administration (FDA) announced its ruling requiring food labels to specify the amount of trans fatty acids (TFAs) present in products, media coverage was prodigious, completely one-sided, and lacking in any scientific perspective.

The take-home message was simple (and false): TFAs are a major cause of heart disease, and consumers need information so they can avoid consuming them.

Journalists, as well as the government officials and self-appointed consumer advocates they interviewed, warned us that this "stealth fat" was an "artery-clogger" that "lurked" in our food.

Incredibly, in all the media coverage I reviewed, no scientists stepped forward with a serving of reality about the alleged relationship between trans fats and mortality. Let me try to remedy this one-sided view by offering another perspective.

A Serving of Reality

First, coronary heart disease is the leading cause of death in the United States, killing more than 500,000 of us annually. While a substantial portion of these deaths occur among the elderly, many other deaths are premature and could be prevented (in the sense that they could be postponed) through appropriate medical and lifestyle interventions.

Second, the top three preventable causes of heart disease—about equal in their impact—are cigarette smoking, high blood pressure (hypertension), and elevated blood cholesterol. (The other important risk factors, such as age and gender, are not modifiable.)

No one is arguing that trans fats affect the first two risk factors, smoking and high blood pressure. But what role do TFAs play in raising blood cholesterol?

As is the case with saturated fats, trans fats can raise blood cholesterol (and adversely affect the subsets of "good" and "bad" cholesterol). But dietary factors are just one of the elements—possibly minor for many people—responsible for unhealthy cholesterol profiles. Other factors, including genetics, may be more important. And medication, not diet, is frequently the most effective solution for reducing cholesterol levels and preventing coronary heart disease.

While high blood cholesterol levels (and low levels of "the good cholesterol," HDL) are established risk factors for coronary heart disease, the role of specific dietary factors such as TFAs is much less clear.

Third, when consumers hear trans fats hyped as a "cause" of heart disease, they are deprived of the broader picture and may overlook the far greater risks of smoking and high blood pressure. Worse, they may conclude that, as long as they count their trans fats, it's not as important to monitor the rest of their diet.

Consumers chasing down trans fat data may take their eye off the real target in dietary risks for disease: obesity. We should focus primarily on calories—both the amount we eat and the amount we burn in exercise.

"The government estimates that perhaps 250 to 500 coronary heart disease deaths (out of the total 500,000 that occur annually in the U.S.) will be prevented. But those numbers are purely hypothetical: The real number of lives saved might be zero."

Fourth, the food industry uses trans fats for a reason. These substances are formed during the process of hydrogenation, which converts unsaturated liquid fats into solid ones. Among other things, the resulting trans fats prolong shelf life because hydrogenated fats are not as susceptible to oxidation as unhydrogenated ones.

Thus the trans fat-containing oils are slower to lose their flavor and are more useful for frying foods. Since hydrogenation has a useful function, consumers will pay a price—in dollars and in food quality—if fewer trans fats are used.

Questionable Benefits

Each additional attempt to reformulate food or add another label to existing food in response to government mandates or public fears increases food production costs. That contributes to raising the price of food—an economic reality that hits low-income Americans hardest, since they spend a greater portion of their disposable income on food.

What are we to get in return for the higher costs (and, presumably, more limited food choices) that will come with the labeling and phasing out of trans fats?

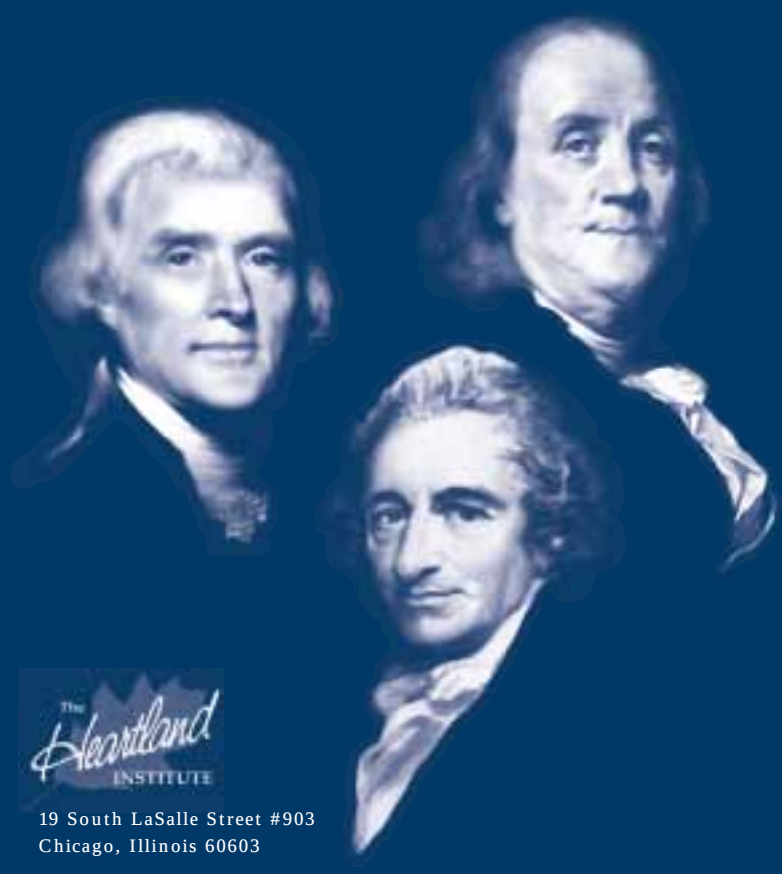
The government estimates that perhaps 250 to 500 coronary heart disease deaths (out of the total 500,000 that occur annually in the U.S.) will be prevented. But those numbers are purely hypothetical: The real number of lives saved might be zero.

Public health scientists who know the facts should find the media's out-of-proportion characterization of trans fats as a heart health risk very troubling. Indeed, these scientists should place a good part of the blame on themselves.

While it would be easier to blame the media for serving up a half-baked story on trans fats and health, the reality is that few, if any, knowledgeable scientists who had a grasp of the broader public health issues made an attempt to step forward and challenge the demonization of trans fats.

Dr. Elizabeth M. Whelan is president of the American Council on Science and Health. Her email address is **acsh@acsh.org**.

The Heartland Institute's 19th Anniversary Benefit



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